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MEMORANDUM

TO:	Senate Health Policy Committee
FROM:	Health Care Association of Michigan (HCAM)
RE:	Nursing Facility Employment of Physicians – HB's 5375, 5376 and 5377 Paid Dining Assistants – HB 5389 Clinical Process Guidelines – SB 938
DATE:	May 27, 2014

Senator Marleau, committee members, my name is Carolyn Anderson. I am with NexCare Health Systems headquartered in Brighton, Michigan. NexCare operates 17 nursing and rehabilitation facilities throughout the state. I also serve as the current board chair of the Health Care Association of Michigan. Thank you for the opportunity to discuss House Bills 5375, 5376 and 5377 addressing the issue of proprietary nursing facilities directly employing physicians, HB 5389 regarding paid dining assistants and SB 938 addressing Clinical Process Guidelines.

House Bill 5375 amends the Public Health Code to establish that a nursing facility's license includes within its scope not only room, board and nursing care, but physician care. House Bills 5376 and 5377 amend the Business Corporation Act and Limited Liability Company Act to allow an exception to the "learned profession" doctrine for nursing facilities to hire physicians.

The legislation clarifies the "learned professions" doctrine, also known as the "corporate practice of medicine" doctrine that prohibits proprietary nursing facilities from directly hiring physicians for resident care.

One of the philosophical underpinnings of the learned professions doctrine has been concern that profit motive will corrupt the purity of professionalism that society deserves, which has contributed to an exception to the Michigan doctrine. A nonprofit corporation might safely offer professional services through employment and a business corporation cannot. Thus, in the extended care world, Michigan has an odd dichotomy: nonprofit institutions may hire their own physicians, while proprietary entities cannot.

Initiatives in the Patient Protection and Affordable Care Act ("PPACA") intensified the federal movement from compartmentalized health care, calling for the creation of Accountable Care Organizations (ACO) and managed care for the "dual" eligibles. At root, ACOs serve the same goal in integrating institutional and professional services, with interdisciplinary sharing of case management. For nursing facilities, it means careful management of hospital readmissions, working with their ACO "partners" to minimize returns to hospital inpatient settings.

Similarly to the ACO's, the impetus behind integrated care for "dual" eligibles is the integration and coordination of patient care transitions through the different health care settings. Managed care organizations will be looking for step down alternatives to hospital stays and competent providers capable of caring for complex physical conditions out of the hospital setting. Nursing facilities will have to develop clinical specialties and improve existing clinical skills.

Further, the residents in nursing facilities today have come to resemble those in general hospitals two decades ago, requiring more specialized therapy and complex medical treatments. Nursing facilities are reaching the limits of the traditional model of independent physician services in their facilities. An obvious step is to follow the lead of many hospital systems, and add physicians known as "hospitalists" to the employed staff, where, free of the competing obligations of private practice, physicians concentrate on developing coordinated care.

Nursing facilities across the country are starting to explore this option as well. Hiring what is affectionately called a "SNFist." This will allow for meaningful care as physicians in facilities on a daily basis will get to know residents and families very well. They will identify immediately a decline in a resident's health and start treatment before it becomes acute and potentially avoid a hospitalization. Preventing hospitalizations is key, as it not only provides better care, but saves Medicare and Medicaid dollars.

The healthcare landscape is significantly changing. Nursing facility providers need tools in the tool box. Ultimately, this option will lead to the facility physicians, the primary-care doctors and hospitals working together as a unified team to ensure the best care.

I would also like to speak to House Bill 5389 which amends the Public Health Code to allow utilization of paid dining assistants. House Bill 5389 would implement federal regulations that were established as an option for nursing facilities nationwide in 2005.

Paid dining assistants provide one-on-one attention during meal and snack times for residents whose conditions do not include complicated feeding needs. They enhance the dining experience of long term care residents who may need nutrition and/or hydration encouragement to promote optimal resident outcomes.

The Center for Medicare and Medicaid Services (CMS) require states to adopt the federal regulations that outline the training and rules necessary to utilize paid dining assistants. The Department of Licensing and Regulatory Affairs must approve a curriculum that nursing facilities will use to train dining assistants.

The legislation is not a mandate...it is only an option for nursing facilities. It does not require licensure or certification of paid dining assistants.

In 2003, the Michigan Department of Consumer and Industry Services initiated the Nursing Home Dining Assistance Project allowing several nursing facilities in the state to hire dining assistants. Michigan State University evaluated the results of the pilot project. Evaluated outcomes revealed the social dining experience of the residents was enhanced and safety of the residents was protected. In addition, the CMS and the Agency for Healthcare Research and Quality commissioned a nationwide study to evaluate the federal paid feeding assistant regulation. Results of this study indicate this regulation may serve to increase the utilization of existing non-nursing staff to improve feeding assistance care during meals without having a negative impact on existing nurse aide and licensed nurse staffing levels.

At least 28 states have successfully implemented a paid dining assistant program consistent with the federal regulatory requirements referenced previously. In 2007, the federal agency with oversight responsibility for nursing facilities further enhanced the regulations to provide for robust monitoring of dining assistant programs through the annual comprehensive survey process that measures nursing facility performance on a continuous basis. In general, facility-based paid dining assistant programs recruit and provide specialized training to an appropriate ratio of non-nursing service staff already employed by the facility with some new hires to augment staff available to assist residents during meal times and snack times. Evaluated programs demonstrate a high level of resident, family and staff satisfaction with the programs.

Change is afoot in long-term care. Michigan has entered an era of rapid growth for our aging population and will be challenged along many fronts to provide quality services. As I have mentioned, nursing facilities need as many tools in the tool box as possible to meet this demand. Both options of hiring physicians and dining assistants will aid in this effort.

Lastly, I would like to briefly address SB 938. In 2012, Public Act 322 sponsored by Senator Geoff Hansen, provided a comprehensive update to the survey and enforcement process of Michigan's nursing facilities. The legislation, in part, required the biennial update of all Michigan specific Clinical Process Guidelines (CPG.) The CPG's were put in place a decade earlier as a tool for nursing facilities to establish a commonly held standard of practice in certain clinical process areas and to promote common understanding and consistent decision making in the state oversight process of nursing facilities. They served their purpose well, resulting in improved resident outcomes. Some of the CPG clinical areas include; prevention of pressure ulcers, nutrition, hydration, dementia and falls.

Public Act 322 also established a Clinical Advisory Committee comprised of individuals from the Department of Licensing and Regulatory Affairs, provider associations, the Long-Term Care Ombudsman Office, the Michigan Chapter of the American Medical Directors Association and the Michigan Peer Review Organization. The committee was asked to review and update, the current set of Michigan Clinical Process Guidelines, as appropriate.

Following a thorough review, the committee determined that in the intervening years since Michigan specific CPG's were established many other nationally-recognized, evidence-based clinical process guidelines and best practice resources have become available and are being widely used by providers for the purpose of improving and maintaining the quality of care for residents. For example, the American Medical Directors Association currently publishes and regularly updates clinical process guidelines specific to nursing facility practice on twenty-two clinical topics (a menu far greater than the clinical topics included in the Michigan CPGs). More are being developed. These resources, and others, are developed by and vetted through national experts in geriatric medicine. Based upon the availability of superior nationally-recognized, evidenced-based guidance, the Committee recommended the outdated Michigan CPGs be eliminated. The Committee took its recommendation and the support data for its position to the LARA Stakeholders Workgroup, where it was thoroughly considered and unanimously supported. These recommendations were brought to the sponsor of PA 322 of 2012 for reconsideration and were determined to be appropriate, hence introduction of SB 938.

What is most important is that facilities use an evidence-based, nationally-recognized clinical process guideline or best practice resource for development and implementation of operational policies and evaluation of performance in all critical areas of clinical practice. SB 938 establishes that standard and reinforces an expectation for superior clinical performance confirmed by the state oversight process for all nursing facilities.